www.gpscbc.ca/system/files/GPSC_Attachment_Initiative_Billing_Guide_July-2013.pdf
or still available by Feb.14 2016 at the following two links:
https://divisionsbc.ca/Media/WebsiteContent/5631/GPSC_Attachment_Initiative_Billing_Guide_July-2013%20%282%29.pdf
Or
https://divisionsbc.ca/Media/WebsiteContent/5631/GPSC_Attachment_Initiative_Billing_Guide_July-2013 (2).pdf

GP SERVICES COMMITTEE
"A GP For Me"
Attachment INITIATIVE

2013

BCMA
BRITISH COLUMBIA MEDICAL ASSOCIATION

BRITISH COLUMBIA

Society of General Practitioners

Attachment "A GP for Me" Initiative

A GP for Me was developed in response to the following facts:

- Studies in BC and internationally demonstrate the benefits of a strong primary care system centered on longitudinal doctor-patient relationships: fewer hospitalizations, reduced pressure on Emergency Rooms, improved patient health outcomes and reduced population health care costs.
- In BC, Hollander Analytical Services determined that higher levels of attachment between a patient and family physician leads to better outcomes and significant cost savings for higher-needs patients. The study projected that an increase of 5 per cent in attachment for these patients would results in a cost savings of about $85 million annually.

In British Columbia, however, access to a family physician can be challenging. Many people who already have family doctors have difficulty being seen on an urgent basis. In addition, there are a significant number of people who are unable to find a family doctor at all, despite actively looking. Based on Canadian Community Health Survey data, the Ministry of Health estimates that 615,000 British Columbians (nearly 14%) don't have a regular family physician, and 176,000 (just under 4% of the population) are looking for one. Lack of access to a family physician creates health inequities. People without a regular care provider seek care through walk-in clinics or emergency departments, resulting in fragmented care, poor outcomes and increased system costs.

Lack of access to a family physician has been identified as an important public issue, leading the Minister of Health to announce in 2010 a government commitment to provide a family doctor for any British Columbian who wishes one by the year 2015.

The GPSC realizes that asking FPs to simply work harder or longer to absorb the poorly attached and unattached populations, however, is not feasible. We are in a state of provider shortage and practicing physicians already indicate that they are burning out from workload stress.

To improve overall levels of attachment, the capacity of primary care in BC must increase. It is believed that this can be best achieved through a number of complementary strategies at the practice, regional, and system levels to improve the efficiency and organization of care.

Program Goals

The goals of "A GP for Me" are:

• To confirm and strengthen the GP-patient continuous relationship, including better support for the needs of vulnerable patients;

• To enable patients that want a family doctor to find one; and

• To increase the capacity of the primary health care system.

PRACTICE FEE SUPPORTS

At the physician practice level there will be new fees intended to help increase the efficiency of individual practices and develop their capacity to take on new patients.

- These fees will include a major expansion to the ability to conduct paid telephone visits with patients.
- Also included will be a fee to better compensate doctors for the additional time it takes to provide care for patients with chronic complex conditions.
- A new incentive is being provided to enable physicians to take more patients with high needs, such as cancer, onto their caseloads.

DIVISION SUPPORTS

At the community level Divisions of Family Practice will have access to $40 million in funding distributed over the next three years to:

- Evaluate their community composition including the number of people looking for doctors, the services being delivered, the needs of the local family physicians, and the strengths and gaps in local primary care resources; and
- Develop and then implement a community plan for improving local primary care capacity, including a mechanism for finding doctors for patients who are looking for one, and attending to the needs of vulnerable patients. Solutions will vary from community to community.
- Work will include:
    - Engagement with FPs, Health Authorities (through the CSC) and other health care providers - collaborative problem identification
    - Comprehensive assessment of local primary care system
    - Development and implementation of plan to address system issues

INTEGRATION WITH EXISTING PROGRAMS

A GP for Me is just one part of the strategy, and will be integrated with other GPSC, Health Authority and Ministry of Health initiatives, including:

- Integrated Primary and Community Care Strategy
- NP4BC
- Practice Support Program/Physician Information Technology Office IT alignment
- Better at Home Program
- Home Health Monitoring
- After-hours Palliative Nursing Services
- Seniors' Action Plan
- Partnerships with non-governmental organizations providing patient self-management supports

GPSC Incentives for A GP for Me/Attachment

It is the intent of the General Practice Services Committee to make initiatives available to Family Physicians voluntarily participating in the 'A GP for Me' program, also known as the Attachment initiative, which would not otherwise be accessible.

The fee codes for the Attachment initiative will be available to all family doctors who submit the MSP fee G14070 'GP Attachment Participation Code', a zero-sum amount, at the beginning of each calendar year. This will in turn open the door to the new Attachment initiative suite of fees. Billing the zero sum fee code signifies that:

- You are providing full-service family practice services to your patients, and will continue to do so for the duration of that calendar year.
- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'compact'. Refer to A GP for Me –Frequently asked questions Q6 for details.
- You have contacted your local division of family practice to share your contact information and to indicate your desire to participate in the community-level Attachment initiative as you are able. Refer to A GP for Me - Frequently asked Questions Q20 and Q21 for more information.

Prior to submitting the GP Attachment Participation Code, each participating Family Physician must register their intent to participate in A GP for Me with their local division, even if he/she is not a member of that local division. This will assist the local division to understand how many doctors in their area are prepared to support Attachment initiative efforts. Division contacts are available online at www.divisionsbc.ca.

The standardized wording of the Family Physician-Patient 'Compact' was developed in consultation with the physicians of the three Attachment prototype communities and in consultation with members of the Patient Voices Network. The compact states:

As your family doctor I, along with my practice team, agree to:

- Provide you with the best care that I can
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my patient I ask that you:

- Seek your health care from me and my team whenever possible and, in my absence, through my colleague(s), xxxxxx
- Name me as your family doctor if you have to visit an emergency facility or another provider
- Communicate with me honestly and openly so we can best address your health care needs

GPSC also recognizes that when locums are working for a Family Physician who is participating in the attachment initiative they should have the opportunity to provide the same services to those patients when this is agreeable to the host physician.

Therefore, the fee codes for the Attachment initiative will be available to all locum GP's who submit the MSP fee G14071 'GP Locum Attachment Participation Code', a zero-sum amount, when they are providing locum coverage in a family practice subject to the services allowed in the locum agreement between the locum and the host family physician. **Fee item G14071 is effective April 1, 2013 and may be submitted to MSP commencing May 30, 2013.** In subsequent years, G14071 should be submitted at the beginning of the calendar year or prior to providing the first locum coverage for a family physician participating in the attachment initiative. Billing the zero sum fee code signifies that:

- You are providing full-service family practice services to the patients of the host physician, and will continue to do so for the duration of locum coverage for a family physician participating in the attachment incentive.
- You have contacted the Divisions of Family Practice central office to share your contact information and to indicate your desire to participate as a locum in the community-level Attachment initiative as you are able. Refer to A GP for Me - Frequently asked Questions Q20 and Q21 for more information.

General Notes:
The Attachment incentives are available for BC residents only; reciprocal are excluded.
Rural retention premiums do not apply.

1. Attachment Participation

G14070 GP Attachment Participation Code $0.00

The GP Attachment Participation Code should be submitted at the beginning of each calendar year by Family Physicians (FP)'s who choose to participate in the GPSC Attachment Initiative. Once successfully processed by MSP, the FP may access the "Attachment participation" incentives (G14074, G14075, G14076, and G14077).

Submit fee item G14070 GP Attachment Participation Code using the following "Patient" demographic information:

PHN#: 975 303 5697
Patient Surname: Participation
First name: Attachment
Date of Birth: January 1, 2013
ICD9 code: 780

Submission of this code signifies that:

- You are providing full-service family practice services to your patients, and will continue to do so for the duration of that calendar year.
- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'compact'. Refer to A GP for Me –Frequently asked questions Q6 for details.
- You have contacted your local division of family practice to share your contact information and to indicate your desire to participate in the community-level Attachment initiative as you are able. Refer to A GP for Me - Frequently asked Questions Q20 and Q21 for more information.

Notes:

i) Bill once per calendar year to confirm participation in the Attachment initiative.
ii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.
iii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
iv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care. (See FAQ #6.30 for the definition used by GPSC regarding physicians under APP)

Frequently Asked Questions about G14070 - GP Attachment Participation Code:

1.1 How do I bill for the GP Attachment Participation code (G14070)?

The Attachment Initiative requires participating FPs to notify their local Division of Family Practice (if one exists) of their willingness to participate as they are able. Once the DoFP has been notified the, the FP must submit the GP Attachment Participating Code G14070 in order to then have access to the additional Attachment Fee supports. Subsequently, at the beginning of each calendar year, participating FPs are to re-submit fee item G14070 GP Attachment Participation Code indicating their intention to continue to participate in the program. To submit code G14070 use diagnostic code **780** and the following program "Patient" demographic information:

PHN#: 975 303 5697
Patient Surname: Participation
First name: Attachment
Date of Birth: February 12, 2013

Once processed by MSP, this will then allow access to the other Attachment Portal fees.

1.2 What are the new incentive fees is available to family doctors who participate?

The new attachment fees that are available to family physician as of April 1, 2013, include:

- **G14074 GP Unattached Complex/High Needs Patient Attachment Fee**
- **G14075 GP Attachment Complex Care Management Fee**
- **G14076 GP Attachment Telephone Management Fee**
- **G14077 GP Attachment Patient Conferencing Fee**

These fee codes for the Attachment initiative will be available to all family doctors who submit through MSP the GP Attachment Participation code (G14070) of a zero-sum amount at the beginning of each calendar year, which will in turn open the door to the new Attachment initiative suite of fees. Billing the zero sum fee code also signifies to the division that you, as a physician, are willing to participate in the community-level Attachment initiative to the degree that you are able.

1.3 Will the billing of this trigger any indication that the physician is now taking new Patients?

The submission of code G14070, the GP Attachment Participation Code, will NOT trigger anything regarding the FP taking on new patients. The ability and willingness of individual FPs to accept new patients is voluntary and as they are able. The GPSC is hopeful that with the Attachment supports (Practice, Divisional and System level); participating FPs will take on some of the unattached patients in the target population under the Unattached Complex/High-needs Patient Attachment initiative (G14074).

1.4 Are Family Physicians working in focused practices eligible to participate in the Attachment Initiative and access the Attachment and other GPSC fees?

The intent of the Attachment Initiative and its incentives is to facilitate the attachment of currently unattached complex/high-needs patients as well as support the relationship between patients (both already attached and newly attached) and their personal Family Physician. It is this longitudinal relationship and the provision of the broad spectrum of services of Family Medicine (Prevention, Acute needs and Chronic Disease management, etc.) as opposed to focused practices organizing the care around a specific area – HIV, Addictions, Mental Health, etc. that all the GPSC incentives (except the GP with Specialty Training) were developed to support. If a Family Physician is committing to the provision of this broad spectrum of services and not just the services focused on a specific condition for patients who are attached to the FP, regardless of location of the provision of these services (ie. whether in own community FP office or through a focused practice clinic) then that FP is eligible to participate in the Attachment Initiative and can the access the Attachment (and other) GPSC incentives.

GPSC cautions FPs to remember the intent and mandate of the focused practice area as these have often been developed to provide enhanced services to a broader population specifically around the relevant conditions, and by taking patients into the FP practice in an there may be the unintended consequence of reducing capacity for providing these services.

1.5 How do Full Service Family Physicians providing longitudinal comprehensive care in a shared group setting participate in the Attachment Initiative?

The intent of the Attachment Initiative and its incentives is to facilitate the attachment of currently unattached complex/high-needs patients as well as support the relationship between patients (both already attached and newly attached) and their personal Family Physician. It is this longitudinal relationship and the provision of the broad spectrum of services of Family Medicine (Prevention, Acute needs and Chronic Disease management) that all the GPSC incentives (except the GP with Specialty Training) were developed to support.

Being in a shared practice does not remove the need to have a FP who is still responsible for this coordinating role. Therefore, while there is no requirement to submit an attachment code to MSP indicating which FP any patient is attached or assigned to, in the patient record there must be a specific FP who is committing to the provision of this broad spectrum of services and taking on the overall responsibility of the coordination of the care needs for the patient even if the care is shared with others. This could be done based on who saw a new patient for intake, or for existing patients, assigned to the FP who provided the majority of services or if there no identifiable individual "Most Responsible Family Physician" (MRP) evident is then assigned under some sharing agreement across the FPs in the group practice. Previously groups such as these have been given permission to bill for GPSC incentives provided they assign each patient to one member of the group as the MRP FP, preferably the one who is the Majority Source of Care provider.

G14071 GP Locum Attachment Participation Code $0.00

The GP Locum Attachment Participation code should be submitted by the GP who provides locum coverage for a Family Physician participating in the Attachment initiative at the beginning of the calendar year or prior to the start of the first such locum in each calendar year. Once processed by MSP, the locum may access GP Attachment incentives for services provided while covering for the Attachment participating host FP. The Locum and Attachment participating host FP must discuss and mutually agree on which of the GPSC Services including those covered through the Attachment Initiative may be provided and billed by the locum.
To submit fee item G14071 GP Attachment Locum Participation Code use diagnostic code 780 and the following "Patient" demographic information:

PHN#: 975 303 5697
Patient Surname: Participation
First name: Attachment
Date of Birth: January 1, 2013

Submission of this code signifies that:

- You are providing full-service family practice services to the patients of the host physician, and will continue to do so for the duration of locum coverage for a family physician participating in the attachment incentive.
- You have contacted the Divisions of Family Practice central office to share your contact information (AGPforMe@bcma.bc.ca) and to indicate your desire to participate as a locum in the community-level Attachment initiative as you are able. Refer to A GP for Me - Frequently asked Questions Q20 and Q21 for more information.

Notes:

i) Bill once per calendar year at the beginning of the year or prior to the first locum coverage for a family physician who is participating in the attachment initiative.
ii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.
iii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
iv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

(See FAQ #6.30 for the definition used by GPSC regarding physicians under APP)

Frequently Asked Questions about G14071 GP Locum Attachment Participation Code:

1.6 Which of the Attachment Incentive fees, if any, can a locum bill when working in an Attachment Participating Practice?

There needs to be a discussion between the host FP and the locum as to the provision of any service that is covered by any GPSC incentive regardless if the host FP is participating in the Attachment Initiative or not. Many of the GPSC incentives are for services or care that goes beyond the individual visit. For example, both Complex Care incentives include planning visit and pre-payment for time, intensity and complexity in the coming year, not just for the duration of the locum. Since the host FP is responsible for the follow-up management of the care incented through the initiatives, there must be agreement that it would be appropriate for the service to be provided by the locum. There are also implications in how the provision of these services and the resulting billing of the incentive fees will be treated in the locum agreement for fee splitting/payment. The host FP and locum must come to an agreement on this issue prior to any GPSC incentives being billed on behalf of services provided by locums. (See Appendix 1. For SGP Locum checklist)

The following are the Attachment Incentive codes that can be billed on behalf of locums:

1. **G14071 – GP Locum Attachment Participation Code**

Since locums have no longitudinal practice of their own, they do not need to bill the G14070 Attachment participation code. However, in order to facilitate the billing for services provided by the locum covering in an Attachment participating practice, the GPSC has developed the GP Locum Attachment Participation Code G14071 which will remove the need to submit any e-notes when billing any of the Attachment Incentive fee codes. **Fee item G14071 is effective April 1, 2013 and may be submitted to MSP commencing May 30, 2013.** In subsequent years, G14071 should be submitted at the beginning of the calendar year or prior to providing the first locum coverage for a family physician participating in the attachment initiative. To submit code G14071 use diagnostic code **780** and the following program "Patient" demographic information:

PHN#: 975 303 5697
Patient Surname: Participation
First name: Attachment
Date of Birth: February 12, 2013

2. **G14074 – Complex/High-needs Unattached Patient Attachment Fee**

If the host FP is agreeable to the locum seeing a new patient to provide the review of past history and discuss the needs of the patient in planning for care into the future, then this service is billable with fee code G14074 Complex/High-needs Unattached Patient Attachment Fee for the provision of this intake service by the locum, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

3. **G14075 – Attachment Patient Complex Care Fee – Frailty Level 6 or 7**

If the host FP is agreeable to the locum seeing a patient eligible for the Attachment Complex Care incentive to provide the planning visit as per fee description, then this service is billable with fee code G14075 Attachment Patient Complex Care Fee for the provision of this service by the locum, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

4. **G14076 – Attachment Patient Telephone Fee**

Locum physicians are eligible to have the G14076 Attachment Patient Telephone Fee billed for telephone calls provided to patients when covering an Attachment participating host FP. Each locum will still have the same 500 telephone call fees per calendar year available, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

Note: An electronic note "Dr. A covering/locuming for Dr. B pract #XXXXX" is still required in order to bill G14079 – GP Telephone/e-mail follow-up

management fees for patients on whom the host FP has been paid one of the portal planning related fees 14033, 14043, 14053, 14063 or 14075.

5. G14077 – Attachment Patient Conference Fee

Locum physicians are eligible to have the G14077 Attachment Patient Conference Fee billed for conferencing with allied health professionals when covering an Attachment participating host FP, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

2. GP Unattached Complex/High Needs Patient Attachment Incentive

G14074 GP Unattached Complex/High Needs Patient Attachment Fee $200

The Unattached Complex/High Needs Patient Attachment fee is intended to compensate for the often time consuming and intensive process of integrating a new patient with higher needs into a family physician's practice. This fee is paid in addition to the visit fee, and covers the initial meetings, organization of a medical record, and organization and enactment of appropriate Clinical Action Plan(s) as discussed with the patient.

Once a Complex/High-needs patient has been accepted into the longitudinal, the other GPSC incentives become available (eg. CDM, Complex Care, Mental Health Planning) if the patient meets the eligibility requirements.

Billing this incentive requires the accepting family physician to collate and review the relevant patient record to date and to meet with the patient to discuss this information and determine what supports will be needed to provide for the patient's ongoing medical needs, taking into account his/her personal goals of care. By billing this incentive, the FP commits to providing ongoing longitudinal care for the patient accepted into the FSFP practice. The patient populations eligible for this intake fee are:

- ✓ Frail in Care (CSHA Clinical Frailty Scale score of six or more in residential care – new admissions only with exceptions for extenuating circumstances such as sudden departure from practice of existing MRP FP)
- ✓ Frail in the Community (CSHA Clinical Frailty Scale score of six or more)
- ✓ Significant Cancer
- ✓ Moderate to High Needs Complex Chronic Conditions
- ✓ Severe Disability in the community
- ✓ Mental Health and Substance use
- ✓ New Mother and Infant(s) (intake can occur at any time during pregnancy up to 18 months of age. Each mother/child(ren) dyad counts as one unit for the purpose of billing this fee code) – ***Note: Use the mother's PHN and Dx code 01N when attaching a pregnant patient or Mother/baby dyad.***

Notes:

i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 on the same or a prior date in the same calendar year.

ii) Payable only for unattached new patients who have been referred from Acute Care: ER and Admitted, Mental Health/Substance Use Workers/Clinics, Home and Community Care, BC Cancer Agency or Regional Centres, Public Health Colleagues, Ministry of Children and Family Development (MCFD)/local social services professionals, Local Division and do not already have a Family Physician. Patients who are already attached to a family physician in the same community are not eligible (i.e. Not for transfers between FPs unless moving to a new community).

iii) Visit fee to indicate face-to-face interaction with patient same day must accompany billing.

iv) Payable in addition to office visit, home visit or residential care visit same day.

v) G14077 GP Attachment Conference fee payable on same day for same patient if all criteria met.
vi) G14033, Complex Care Management Fee and G14075 GP Attachment Complex Care Management Fee not payable on same day for same patient.
vii) Not payable for patients located in acute care.
viii) G14015 Facility Patient Conference fee, G14016 Community Patient Conference Fee, and G14017 Acute Care Discharge Planning fee not payable in addition, as these fees not payable to FPs who have submitted the GP Attachment Participation Code. Instead, these physicians should use G14077 GP Attachment Conference fee
ix) Maximum of 5 complex care fees (G14033 and/or G14075) and/or GP unattached complex/high needs patient attachment fees (G14074) per day per physician.
x) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
xi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

(See FAQ #6.30 for the definition used by GPSC regarding physicians under APP)

Referral Sources may include physicians, allied healthcare professionals or other coordinators from the following locations or programs/areas:

- Acute Care: ER and Admitted
- Mental Health/Substance Use Workers/Clinics
- Home and Community Care
- BC Cancer Agency or regional centres
- Public Health
- Ministry of Children and Family Development (MCFD)/local social services professionals
- Colleagues
- Local Division
- Patients cannot self-identify

Frequently Asked Questions about G14074 GP Unattached Complex/High Needs Patient Attachment Fee:

2.1 What is required to bill for the GP Unattached Complex/High Needs Patient Attachment Fee (G14074)?

GPSC has decided to focus initially on higher needs unattached patients (see fee description above for target population) who would most benefit from being attached to an FP for their ongoing care needs. The Unattached Complex/High Needs Patient Intake fee is intended to compensate for the often time consuming and intensive process of integrating a new patient with higher needs into a full service Family Physician's practice. This fee will be paid in addition to appropriate visit fee, and will cover the initial meeting, organization of a medical record, organization and enactment of appropriate Clinical Action Plan(s) as discussed with the patient. Billing this incentive requires a review of the relevant patient record to date and meeting with the patient and/or the patient's medical representative to discuss this information and determine what other supports will be needed to provide for the patient's ongoing medical needs, taking into account his/her personal goals of care. By billing this incentive, the FP commits to providing ongoing longitudinal care for the patient accepted into the FSFP practice.

In order to facilitate the identification of eligible patients, it is expected that patients will be referred to the FP. The initial source and process for referrals can be found in the fee specific background information. The referral does not need to come from a physician but can be provided by Care Provider working within the referral center provided they have the capability to determine/confirm that the patient being referred meets the target population requirements.

2.2 Why is a referral required and is a formal referral either using a referral form or by submitting anything through MSP required in order to bill fee item G14074 Complex/High-needs Unattached Patient Attachment Fee for accepting these patients into a Full Service Family Practice?

The requirement of a "referral" is to embed a vetting/triaging process to ensure that patients being accepted into a Community longitudinal family physician's practice meet the requirements/intent of the incentive. It can be a written request/referral (paper, fax, secure e-mail) or it can be a verbal request. Once the request to take on the patient has been accepted, the new FP must document in the chart who "referred" the patient and what the patient's qualifying conditions are, followed by the usual Allergies, Medications, Past Medical Hx, Family History and then the review of conditions and the plan for management that has developed jointly with the patient. The referring physician or agency does not need to document the referral in their chart/file for the patient. There is no need for a formal referral to be submitted through Teleplan or to the local division.

2.3 What specific diagnoses qualify in the various broad categories of eligible patients for the GP Unattached Complex/High Needs Patient Attachment Fee (G14074)?

Evaluation of the GPSC incentives has shown that the best return on investment in terms of both outcomes and overall costs, is in higher-needs patients regardless of diagnosis. This is due in large part from the greater the benefit of attachment of these patients to a Family Physician. Rather than developing an extensive list that will always be incomplete, the intent of the "Complex/High-needs Unattached Patient Attachment Incentive" is to attach those patients who will most benefit from being in a strong FP – patient relationship over time. As such, ***the intended target population are to have medical conditions that are of sufficient severity and potential for poor outcomes that ongoing monitoring and management through the planned proactive care that is found within the Full Service Family Physician – Patient relationship will benefit both their quality of life, improve outcomes and lessen the impact of their condition on activities of daily living.*** Having a specific diagnosis or co-morbidities does not necessarily equate to being "Complex" or high-needs. It is expected that Family Physicians participating in the Attachment Initiative will use their clinical judgment to ensure that patients who are accepted under the Unattached Complex/High-needs Patient Attachment fee G14074 in fact do meet the criteria and require the level of time, intensity and complexity as indicated above.

2.4 Will G14074 GP Unattached Complex/High Needs Patient Attachment Fee be applicable for patients of an FP who is retiring or leaving practice for other reason?

If there is a new FP taking over a practice of a doc retiring/leaving, the new FP is not eligible to bill G14074 GP Unattached Complex/High Needs Patient Attachment Fee on any existing patients of practice as all practice infrastructure in existence it is a transition only. New patients referred through the process that is developed locally will be eligible for G14074 GP Unattached Complex/High Needs Patient Attachment Fee.

If there is no FP to take over a practice of a doc retiring/leaving and the leaving FP asks other colleagues (in same clinic or other location) to take on these complex patients, GPSC has agreed that this is an acceptable referral so the FP accepting transfer of these patients will be able to bill the G14074 GP Unattached Complex/High Needs Patient Attachment Fee for eligible patients. Alternatively, the patients could be referred to accepting FPs through the locally determined unattached patient attachment process.

2.5 How do I bill for taking on a new Complex/High-needs patient in residential care/long term care?

When an unattached Complex/High-needs patient is being admitted to residential/long term care and an Attachment Participating FP has been asked to accept the patient into their longitudinal practice, this fulfills the "referral" requirement in order to bill G14074 Unattached Complex/High-needs Patient Attachment fee. The FP will have been advised of the date of admission of the patient and will have been asked to specially come to see the patient to undertake the admission history and physical examination and completion of all required documentation. The resulting assessment visit, if provided between 0800 and 2300 hr any day of the week can be billed using the 00115 "Nursing Home Visit when Specially Called" in addition to the G14074 Unattached Complex/High-needs Patient Attachment fee for the provision of this intake service. When the patient is seen on a different day from the day of the call/request (eg. Called one day about a new patient being admitted later in the week and patient then seen on day of admission) you must use the date and time seen as Date of Service/Time of Service. A note must be included in the patient chart "FP contacted DD/MM/YY by LTC staff for referral of new patient".

If the FP is called at night (2300 - 0800) to see the patient for an urgent issues prior to seeing the patient for the intake service, and the FP decides to complete the intake process at that time rather than returning later in the day, the call out fee 01201 (2300 - 0800 hr physician called and patient seen) plus the out of office age differential visit (13200, 15200, 16200, 17200, 18200) or CPX if medically indicated (13201, 15201, 16201, 17201, 18201) is billable indicating the face-to-face visit has occurred in addition to the G14074. In addition to the time seen, the out-of-office visit/CPX code must be submitted with location code "C" to indicate the location is Residential/ Long Term Care.

2.6 What happens if an FP retires or leaves after working on service contract or sessional agreement with the Health Authority as the MRP physician in a Long Term Care facility and who over the years has taken on a significant number of patients as many office FPs have not wanted to continue to follow patients in LTC?

If the retiring FP asks or the HA/facility staff request an accepting FP to take on these patients, this would be an acceptable referral and these patients are eligible to have the G14074 GP Unattached Complex/High Needs Patient Attachment Fee billed on the day the accepting FP sees the patient to review history, current status and plan for care under the new FP.

2.7 If one of my patients asks me to take on a family member who has recently moved to town or recently become unattached, how can the patient be referred?

A referral from a colleague qualifies. Many FPs work in groups, and showing the chart to your colleague to show that the patient has those qualifying diagnoses and has moved from out of town should be able to result in that colleague saying "Yes, that qualifies from my perspective". The referring doctor (or Division) does not need to see the patient, or send away for corroborating diagnostic information (e.g. spirometry from the hospital where they used to live). The referring doctor simply needs to be given enough information that they would feel comfortable that this patient actually meets the complex/high-needs eligibility requirement.

Alternately, contacting the previous doctor to confirm medical issues, and the fact the patient is moving and so changing doctors would qualify as a referral. The receiving FP needs to make a chart entry that the patient has no local physician, has diagnoses with complexity/high-needs and that your colleague Dr ABC referred them on this basis.

2.8 In a multi-doctor clinic with a Walk In Clinic component, if the WIC doc sees a frail/complex/high-needs patient can he/she refer this person to a regular doc in the longitudinal side of the clinic?

Walk In Clinics can be a source of referral for these patients, but only if they are being referred to an FP who has submitted the Attachment participation code G14070 and as such is committing to provide ongoing longitudinal care to his/her patients, regardless if the FP practice is co-located with the WIC making the referral.

2.9 If an Attachment Participating FP also works in one of the referral source locations (eg. ER, Mental Health, WIC, etc) and has identified his/her willingness to accept patients through the local referral process, how would the referral occur to accept a patient seen through the referral source program?

Referrals do not have to come from another physician but the physician accepting a Complex/High Needs patient MUST have the qualification criteria confirmed before billing the fee. The confirmation can come from a healthcare practitioner in one of the referral sources identified in the fee details. A family physician cannot bill the fee simply by unilaterally identifying. Physician colleagues or Allied Health Professionals located at the referral source may initiate/confirm the referral.

2.10 What happens when an FP who is participating in the Unassigned In-patient Network initiative and has been caring for an unassigned patient in hospital who is also unattached in the community and agrees upon discharge to accept them into their practice?

Physician colleagues or Allied Health Professionals within the hospital (eg. Discharge Planning Coordinator) may initiate/confirm the referral.

2.11 For Maternity patients referred from WIC for maternity/obstetric care to an Attachment Participating FP who subsequently agrees to take the mom (and baby) into his/her longitudinal practice, how is the "referral" done?

The G14074 GP Unattached Complex/High Needs Patient Attachment Fee is billable for Mother/baby dyads at any time during pregnancy to 18 months of age of baby. Therefore, if unattached pregnant patient is referred to a GP who does OB and the referral is to include attachment as well as prenatal care/delivery then the G14074 GP Unattached Complex/High Needs Patient Attachment Fee would be billable with the 14090. If the patient was referred only for the prenatal care/delivery, but then later during the pregnancy, a physician colleague or Allied Health Professional located at the primary OB clinic or at the hospital may initiate/confirm the referral to the GP agreeing to take the patient into the practice.

When accepting a new pregnant patient or mother/baby dyad, submit fee code G14074 GP Unattached Complex/High Needs Patient Attachment Fee with Diagnostic code 01N.

2.12 Can a Midwife refer an Unattached Mom and Baby to FPs participating in Attachment and accepting these patients?

Yes. One of the target populations for the Unattached Complex/High-needs Patient Attachment initiative (G14074) is unattached new moms/babes and they can be referred at any point in the pregnancy up to 18 months of age of the infant. These moms and babes can be referred from the local primary obstetrical providers, whether individual FPs, Midwives or Primary OB clinics (FP and/or midwife). The mother/baby dyad counts as one unit, so the G14074 GP Unattached Complex/High Needs Patient Attachment Fee is to be billed on the mom's PHN. When accepting a new pregnant patient or mother/baby dyad, submit fee code G14074 GP Unattached Complex/High Needs Patient Attachment Fee with Diagnostic code 01N.

2.13 New people to community who are or subsequently become pregnant call around to see who will take them on. In smaller communities, there is no WIC for referral. How can we prevent the requirement of a "referral" from creating a barrier?

Most people who have moved to a new community will contact the local hospital to see if anyone is taking on new patients. If the local Division/Group of FPs decide to participate in the Attachment Initiative, they can determine what the local process would be for these patients. As an example, this could be through the hospital or through a locally advertised contact number to facilitate this referral (eg. a Divisional website link, "hot-line" number, etc).

2.14 What happens if there is a sudden shut down of an office due to loss of FP (death, leaving for personal reasons – retirement with no replacement found) with no provision for transition leaving patients unattached? How can a Division or community to try and get them linked when a referral is required will add a step that may slow the process down?

The referral does not need to come from a physician. The community/division can agree to a process whereby the MOA of the previous physician can refer the patients to accepting FPs in the community. The referral may be made by the local Division process or even their clinic colleague if there is sufficient information that the Division/colleague will feel comfortable that the patients qualify as complex/high-needs.

2.15 In rural and remote communities patients are often cared for by a group of FPs who rotate through the community. None of the patients are specifically attached to one physician, but instead to the group of physicians in the clinic. How do we attach a patient to these groups?

The intent of the Attachment Initiative and its incentives is to facilitate the attachment of currently unattached complex/high-needs patients as well as support the relationship between patients and their personal Family Physician. It is this longitudinal relationship and the provision of the broad spectrum of services of Family Medicine (Prevention, Acute needs and Chronic Disease management) that all the GPSC incentives (except the GP with Specialty Training) were developed to support.

Therefore, while there is no requirement to submit an attachment fee for every patient in a practice, all patients must be attached/assigned within the practice (as indicated on the patient chart) to a specific FP who is committing to the provision of this broad spectrum of services and taking on the overall responsibility of the coordination of the care needs for the patient. Being in a shared practice does not remove the need to have a FP who is still responsible for this coordinating role.

Eligible new patients will need to be assigned to a physician in order to bill the G14074 GP Unattached Complex/High Needs Patient Attachment Fee. The care over the year would be shared between the group of physicians, similar to the manner in which FPs in group/shared practice currently manage the CDM incentives. This could occur based on who saw the patient for the initial intake assessment and setting up of the chart.

2.16 Since the G14074 GP Unattached Complex/High Needs Patient Attachment Fee applies to frail patients in residential care, are palliative patients (Level 7 Frailty) admitted to a free standing hospice or one that is part of a long term care facility, who do not have an FP who can care for them there considered Unassigned and eligible for the G14088 Unassigned In-patient Care Fee or Unattached and eligible for G14074 GP Unattached Complex/High Needs Patient Attachment Fee?

Hospice care is provided in several settings; as part of an acute care hospital, as a free-standing facility, or as part of a long term care facility. At this point in time, FPs providing care for unassigned palliative patients in hospices that are NOT attached to or part of an acute care hospital are not yet eligible for the Unassigned In-patient Network fee and these patients are not eligible for the G14088 Unassigned In-Patient Care fee until GPSC assesses the number and types of hospices around the province to ensure sustainability of the initiative. Patients who are admitted to a hospice that is attached to or part of an acute care hospital and who do not have an FP that will care for them while admitted qualify for the G14088, Unassigned In-patient Care Fee of $150 when accepted under MRP care by members of an Unassigned In-patient Network.

While some patients admitted to hospice are not discharged, other patients may be discharged back into the community following a respite or for symptom control. If that patient has no FP in their community to continue to provide care, they also qualify for the G14074 Unattached Complex/High-Needs Patient Attachment fee when accepted into the community practice of an Attachment participating FP.

If a patient is admitted into Long Term Care/Residential Care with no plan to return to the community setting, and the patient's community MRFP is unable to provide care within the facility, this patient is considered "unattached" within the facility and would be eligible for the G14074 Unattached Complex/High-Needs Patient Attachment fee.

2.17 How long is the FP expected to care for patients he/she has accepted into the practice under fee code G14074 Unattached Complex/High-Needs Patient Attachment fee?

The intent is for these patients to be taken into the practice with a commitment to provide ongoing longitudinal care, in the same manner as any new patient would be accepted.

2.18 What role will the patient have in agreeing to the attachment process? What if the patient doesn't "like" the doc he/she is assigned to?

The patient compact includes the expectations from the patient in the FP/Patient relationship. While there is no requirement that the patient must stay with the FP who has agreed to take him/her on, the incentive will only be billable once unless the patient moves to a different community and is therefore once again "unattached". Therefore if the patient leaves the new practice, any other doctor who is in the same community that agrees to take on the patient will not be able to bill the G14074 GP Unattached Complex/High Needs Patient Attachment Fee. In order to minimize the impact of multiple phone calls to accepting FPs, the GPSC feels a referral process that is community developed to streamline and triage the intake of these patients be used and why "self-referral" is not allowed.

2.19 Will we be allowed to end the Patient-Physician Relationship or are we committed to these new patients forever by the attachment program?

The intent of the Unattached Complex/High-needs Patient Attachment incentive is to accept patients who would most benefit from being attached into your ongoing longitudinal practice. Just as there is always the ability of a patient to leave an FPs practice if they so wish, doctors will still be able to end the Patient-Physician Relationship for appropriate reasons, as long as they adhere to the College of Physicians and Surgeons of BC policies found at:
www.cpsbc.ca/files/u6/Ending-the-Patient-Physician-Relationship.pdf

2.20 What about people who move from other provinces – for the complex/high-needs patients that the incentive is targeting as it is often not appropriate or desirable to have to wait for 3 months for their MSP to come into effect?

The GP complex/High-needs Unattached Patient Attachment initiative is restricted to patients with valid BC MSP coverage.

2.21 Do locums have access to the G14074 Complex/High-needs Unattached Patient Attachment Fee?

If the host FP is agreeable to the locum seeing a new patient to provide the review of past history and discuss the needs of the patient in planning for care into the future, then this service is billable with fee code G14074 GP Unattached Complex/High Needs Patient Attachment Fee for the provision of this intake service by the locum, provided the G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

2.22 Is there a limit to the number of G14074 Complex/High-needs Unattached Patient Attachment Fees that can be billed on a calendar day?

While there is no minimum time requirement included in the rules for billing the Complex/High-needs Unattached Patient Attachment code, the amount of work and time needed to meet with patient and review all past history, medications, develop a plan for management, is similar if not identical to the Complex Care Planning visit. As such, GPSC has included the G14074 GP Unattached Complex/High Needs Patient Attachment Fee with the two complex care codes G14033 (Original) Complex Care Management fee & G14075 Attachment Complex Care Management fee in the maximum of 5 services of any combination of the three per calendar day.

3. GP Attachment Complex Care Management Incentive

GPSC has also received feedback that the initial dual diagnosis-based complex care fee excludes many patients who are also very time and resource intense. While the GPSC has stated that the current complex Care fee will remain unchanged outside the Attachment Initiative, the GPSC has approved broadening the base of the eligible population for the Complex Care Incentive by the addition of other complexities or conditions.

The initial expansion of the Complex Care fee encompasses those patients with a qualifying diagnosis of Frailty as defined by a Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale score of six or more (indicating Moderately or Severely Frail) who do not otherwise qualify under the dual diagnostic eligibility for G14033 Complex Care Management Fee. Patients will qualify only for one of the Complex Care Management Fees, not both.

The GP Attachment Complex Care Management Fee is advance payment for the complexity of caring for patients with eligible conditions and is payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) for the management of the complex care patient during that calendar year. The other requirements for billing the G14075 GP Attachment Complex Care Management fee are the same as the original Complex Care fee: Patients must be "Community Based" = living in their own or a family home or assisted living; Patients in Residential or Long Term Care Facilities are not eligible; 30 minute Complex Care Planning Visit (review of case/chart, current therapies and incorporates the patient's values and personal goals including any wishes regarding future care needs, into the clinical care plan) billed in addition to the appropriate visit code (office visit or house call); the development of the care plan is done jointly with the patient and/or the patient representative as appropriate. **The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is**.

CSHA Clinical Frailty Scale*

1) ***Very Fit:*** robust, active, energetic, well-motivated and fit; these people commonly exercise regularly and are in the most fit group for their age.
2) ***Well:*** without active disease, but less fit than people in Category 1
3) ***Well, with treated comorbid disease:*** symptoms are well controlled compared to those in category 4

4) ***Apparently Vulnerable:*** although not frankly dependent, these people commonly complain of being "slowed up" or have disease symptoms
5) ***Mildly Frail:*** with limited dependence on others for instrumental activities of daily living
6) ***Moderately Frail:*** help is needed with both instrumental and non-instrumental activities of daily living
7) ***Severely Frail:*** completely dependent on others for the activities of daily living, or terminally ill

* Taken from GPAC "Frailty in Older Adults – Early Identification and Management", October 1, 2008 www.bcguidelines.ca/pdf/frailty.pdf

With the 2011 changes to "Health Care (Consent) and Care Facility (Admission) Act" and other Acts, patients with complex comorbidities will also need to know the potential impact on their care. With the initial targeted population through the expansion of the Complex Care Fee being Frailty, the GPSC is in agreement that Advance Care Planning (ACP) is an essential part of the management of all patients, and should be included at the time of the GP Attachment Complex Care Planning visit when clinically appropriate. This has also been included in the background information for the initial Annual Complex Care Planning visit undertaken when billing the G14033.

Advance care planning is the process whereby a capable adult discusses their beliefs, values, wishes or instructions for future health care with trusted family and health care providers. Advance care planning may lead to a written Advance Care Plan (ACP). An ACP is a written summary of a capable adult's beliefs, values, wishes and/or instructions for future health care based on conversations with trusted family/friend and health care provider. The ACP is to be used by a Substitute Decision Maker (SDM) to make health care decisions for the adult when incapable and this may include consent or refusal for treatment. The decisions are to be based on a healthcare provider's offer of medically appropriate care. An Advance Directive is a legal document consenting to or refusing specific treatment options and may or may not be included in the ACP. If it is, then health care providers are legally bound by consent refusals in the advance directive.

G14075 GP Attachment Complex Care Management Fee $315

The FP Attachment Complex Care Management Fee is advance payment for the complexity of caring for patients with eligible conditions and is payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) for the management of the complex care patient during that calendar year. The initial qualifying diagnosis is Frailty with a CHSA Clinical Frailty Scale score of 6 or more.

A complex care plan requires documentation of the following elements in the patient's chart:

- There has been a detailed review of the case/chart and of current therapies.
- There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the GP Attachment Complex Care Management Fee is billed.
- Specifies a clinical plan for the care of that patient's chronic condition(s).
- Incorporates the patient's values and personal health goals in the care plan with respect to the chronic condition(s).
- Outlines expected outcomes as a result of this plan, including any advance care planning for end-of-life issues when clinically appropriate.
- Outlines linkages with other health care professionals that would be involved in the care, their expected roles.
- Identifies an appropriate time frame for re-evaluation of the plan.
- Confirms that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated.

The development of the care plan is done jointly with the patient and/or the patient representative as appropriate. **The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.**

Notes:

i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 on the same or a prior date in the same calendar year.
ii) Payable once per calendar year per patient.
iii) Applicable only to services submitted with diagnostic code V15 for the eligible patient population of frailty.
iv) Visit or CPx fee to indicate face-to-face interaction with patient same day must accompany billing.
v) Payable in addition to office visit or home visit same day.
vi) G14077 GP Attachment Patient Conference fee payable on the same day for the same patient, for patients located in the community only as facility patients not eligible.
vii) Minimum required time 30 minutes in addition to visit time same day.
viii) Maximum of 5 complex care fees (G14033 and/or G14075) and/or GP unattached complex/high needs patient attachment fees (G14074) per day per physician.
ix) G14033 GP Annual Complex Care Management Fee is not payable in the same calendar year for same patient as G14075 GP Attachment Complex Care Fee.
x) G14015 Facility Patient Conference fee, G14016 Community Patient Conference Fee, and G14017 Acute Care Discharge Planning fee not payable in addition, as these fees not payable to FPs who have submitted the GP Attachment Participation Code. Instead, these physicians should use G14077 GP Attachment Conference fee.
xi) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
xii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

(See FAQ #6.30 for the definition used by GPSC regarding physicians under APP)

Frequently Asked Questions about G14075 GP Attachment Complex Care Management Fee

3.1 What are the differences and similarities between the G14075 GP Attachment Complex Care Management Fee and the original G14033 Annual Complex Care Management Fee?

The GPSC received significant feedback that the original complex care incentive was too restricted and as a start to expanding the eligible patient population, developed the new G14075 GP Attachment Complex Care Management Fee for patients who are frail with a CHSA Clinical Frailty Scale score of six or more who do not meet the dual diagnostic criteria of the original G14033 Annual Complex Care Management Fee. FPs participating in the Attachment initiative will have access to the new complex care incentive for existing patients and any new patients taken into their practice who meet the eligibility requirements.

Both Complex Care fees have the same rules:

- ✓ Community Based patients = Living at home or in Assisted Living (excludes those patients living in Residential or Long Term Care where there is 24 hour nursing care available)
- ✓ Payable once per calendar year per patient
- ✓ Visit (office or home visit) or CPx fee to indicate face-to-face interaction with patient same day billed same day.

- ✓ Minimum required time 30 minutes in addition to visit time same day (not all needs to be face-to-face, but development of the care plan is done jointly face-to-face with the patient and/or the patient representative as appropriate. **The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.**
- ✓ Maximum of five complex care or either category or unattached complex/high-needs patient attachment fees (G14033, G14075 and/or G14074) payable per day per physician
- ✓ Payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) for the management of the complex care patient during that calendar year.

3.2 What are instrumental and non-instrumental activities of daily living?

Instrumental Activities of Daily Living = Activities that are required to live in the community:

- Meal preparation
- Ordinary housework
- Managing finances
- Managing medications
- Phone use
- Shopping
- Transportation

Non-Instrumental Activities of Daily Living= Activities that are related to personal care:

- Mobility in bed
- Transfers
- Locomotion inside and outside the home
- Dressing upper and lower body
- Eating
- Toilet use
- Personal hygiene
- Bathing

Patients who require assistance for at least one ADL from each category are defined as Level 6 Frailty.

3.3 Do locums have access to billing G14075 GP Attachment Complex Care Management Fee?

Before any of the Complex Care Incentives (including the Attachment Complex Care Expansion) are billed on behalf of services provided by Locums, the locum and host FP need to discuss the appropriateness and acceptability of this planning process to be provided by the locum. If the host FP is agreeable to the locum seeing a patient eligible for the Attachment Complex Care incentive to provide the planning visit as per fee description, then this service is billable with fee code G14075 for the provision of this service by the locum, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

3.4 Level 7 Frailty includes Palliative Patients. How does this impact the palliative Planning fee G14063?

Not all palliative patients are at the End-of-Life, and it is these "non-EOL" palliative patients who will require ongoing management beyond 6 months that would be appropriate for the G14075. Once they are at End-of-Life (life expectancy 6 months or less and eligible for palliative benefits plan – even if not applied for), the 14063 can be billed for palliative Planning visit provided the 14075 has not been billed in the previous 6 months. If a patient is determined to be in the last 6 months of life and it is decided to provide and bill for the Palliative Planning Visit through fee G14063, the complex care

fees G14075 & G14033 as well as the CDM fees G14050, G14051, G14052 & G14053 are no longer billable.

Both 14075 & 14063 open the door to the GP Telephone/e-mail follow-up management fee (14079) and this is complemented by the additional Attachment telephone fee (14076) but family physicians should use all 5 of the 14079 first before using the limited 14076 (500 per FP per calendar year).

4. GP Attachment Telephone Management Expansion

Telephone and other non-face-to-face 'visits' or 'touches' are a standard component of workflow in other jurisdictions. They have been shown to significantly improve efficiency of care and therefore practice capacity.

While GPSC has already introduced a limited number of these virtual services for specific targeted populations, MSP has not funded their general introduction for the fear that it could push utilization without providing value. In this context, the expansion of telephone 'visits' as part of the Attachment Initiative is seen as an important component of improving practice capacity.

The intent is to avert the need for a patient to be physically seen in the practice in order to increase access for other patients and/or to address urgent problems to avert a patient visit to an urgent care facility or Emergency Department.

They can be used at the discretion of the Family Physician for any patient for whom that Family Physician has assumed the Most Responsible Physician role for any clinical reason that addresses the intent above.

The current GPSC telephone fee (G14079) available for patients on whom a FP has assumed MRP status and has billed a GPSC planning fee (Complex Care, COPD, Mental Health, and Palliative Care) will remain intact outside the portal and will not be dependent upon an FP submitting an Attachment Portal Fee. It is recommended that for patients who are eligible for G14079, these should be utilized first (5 over the 18 months following the provision and billin of the eligible planning fees) before using the G14076 GP Attachment Telephone Management fees due to the limited number per participating FP (500 per calendar year).

G14076 GP Attachment Telephone Management Fee $15

Notes:

i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 on the same or a prior date in the same calendar year.

ii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied health professionals working within the eligible physician office.

iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

iv) Not payable for simple prescription renewals, notification of office or laboratory appointments or of referrals.

v) Payable to a maximum of 500 services per physician per calendar year.

vi) G14077 GP Attachment Patient Conference Fee payable for same patient on same day if all criteria are met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14077.

vii) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077.

viii) Not payable on the same calendar day as the GP Telephone/e-mail fee G14079.

ix) G14015 Facility Patient Conference fee, G14016 Community Patient Conference Fee, and G14017 Acute Care Discharge Planning fee not payable in addition, as these fees not

payable to FPs who have submitted the GP Attachment Participation Code. Instead, these physicians should use G14077 GP Attachment Conference fee

x) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.

xi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care. (See FAQ #6.30 for the definition used by GPSC regarding physicians under APP)

Frequently Asked Questions about G14076 GP Attachment Telephone Management Fee

4.1 What is the difference between the G14076 GP Attachment Telephone Management Fee and the original G14079 GP Telephone/e-mail Management Fee?

The new G14076 GP Attachment Telephone Management Fee has no specific patient diagnostic criteria and has no restrictions on the number of telephone visits that can be billed per patient per year. This new fee is only for telephone management, not e-mail communication. In the prototyping phase for this new non-face-to-face incentive, there will be a cap of 500 telephone fees per participating FP per year. Any patient for whom the FP is the Community MRP FP is eligible to have this code submitted for telephone visits provided by participating FPs.

The original G14079 GP Telephone/e-mail Management Fee is restricted to those patients on whom one of the Planning related fees (G14033 Complex Care; G14043 Mental Health; GP14053 COPD CDM – requires a COPD Action Plan; 14063 Palliative Care; G14075 Attachment Complex Care) has been claimed and is restricted to 5 Telephone/e-mail in the 18 months following the successful billing for one of these portal fees. This is reset each time the portal fee is billed in the subsequent year whether all 5 have been used or not (do not accumulate).

However, patients who are eligible for the original G14079 GP Telephone/e-mail Management Fee are also eligible for additional new G14076 GP Attachment Telephone Management fees if their FP is participating in a GP for Me (attachment). FPs are encouraged to think about how they would spread the restricted number of new Telephone fees they will have access to in this prototyping phase when providing telephone follow-up to patients who would also be eligible under the original telephone/e-mail fee.

Therefore, if a Family Physician thinks he/she will make a lot of these telephone calls, and any of them are for patients who are eligible for the 14076, it would be best to use all 5 of the 14079 for these patients first before using the new 14076. This way, you leave the "arrows in the quiver" for other patients who do not qualify for the 14079 unless you have used all 5 of the 14079 already, then you can use 14076 if you still have any left of your 500 in that calendar year.

4.2 If when making a phone call to the patient there is no answer and a message is left on voice mail, can G14076 GP Attachment Telephone Management Fee be billed?

No, G14076 requires a two-way telephone conversation with the patient.

4.3 Are locums able to provide telephone calls in an Attachment Participating Practice and have G14076 GP Attachment Telephone Management Fee billed?

Locum physicians are eligible to have the G14076 billed for telephone calls provided to patients when covering an Attachment participating host FP. Each locum will still have the same 500 telephone call fees per calendar year available, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

Note: An electronic note "Dr. A covering/locuming for Dr. B pract #XXXXX" is still required in order to bill G14079 – GP Telephone/e-mail follow-up management fees for patients on whom the host FP has been paid one of the portal planning related fees 14033, 14043, 14053, 14063 or 14075.

4.4 Telephone Management requires "a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied health professionals working within the eligible physician office". Which college certified AHPs qualify for making these calls to be eligible for the G14076 GP Attachment Telephone Management Fee to be billed?
14076 Attachment Patient Telephone Call fee - is billable when the telephone call is made by the staff member of the FP office providing she/he is a member of a college certified allied health profession - nurse, NP, LPN, etc. This excludes the Medical Office Assistant. When an RN, LPN or NP is working within her/his scope of practice and is the employee of the FP, these calls are covered. If the AHP has not kept up his/her certification, they would not be working within their scope of practice in the office so would not be eligible. To work within scope of practice and maintain medical legal coverage to do so, all healthcare professionals must maintain certification.
Note: G14079 GP Telephone/e-mail follow-up management fee is payable when the telephone call is provided by the office staff, RN or MOA, when under the direction of the FP, so these calls would be okay for this RN who has not maintained certification and is working as an MOA.

4.5 If the telephone call with the patient is only about a WorkSafeBC covered injury, can G14076 GP Attachment Telephone Management Fee be billed?
When providing a service to a patient regarding an injury that is covered by WorkSafeBC (WSBC), it is not appropriate to bill for these services to MSP or GPSC. However, WSBC has indicated they will consider payment for these calls billed under code 14076 on an individual basis when submitted with WSBC as the insurer. Calls submitted with WSBC as the insurer will not count toward the 500 per calendar year limit submitted under MSP as the insurer. To submit to WSBC for consideration, ensure "W" is listed in the insurer section of the fee submitted through Teleplan.

4.6 Is the use of Text Messaging acceptable in order to bill G14076 Attachment Patient Telephone fee?
G14076, the Attachment Telephone Management fee requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied health professionals working within the eligible physician office. While the G14079 GP Telephone/e-mail follow-up management fee is applicable to two-way e-mails, the G14076 Attachment Patient Telephone fee is only for telephone advice and is not payable for any form of electronic communication including test messages.

5. GP Attachment Patient Conference Fee

The GPSC has received feedback about the complexity of the initial Patient Conferencing incentives. As part of the Attachment Initiative, these concerns have been addressed through a significant simplification as well as expansion of the Attachment Patient Conference fee in order to support improved collaborative care between participating FPs and other health care providers. ***The new Attachment Patient Conference fee will replace all three of the original conference codes (G14015, G14016 & G14017)*** as well as remove a number of other identified barriers that were present in order to bill these codes.

G14077 GP Attachment Patient Conference Fee $40.00 per 15 min or greater portion thereof

Notes:

i. Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 on the same or a prior date in the same calendar year.
ii. Payable only to the Family Physician that has accepted the responsibility of being the Most Responsible Physician for that patient's care.
iii. Details of Care Conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.
iv. Conference to include the clinical and social circumstances relevant to the delivery of care.
v. Not payable for situations where the purpose of the call is to:
    - book an appointment
    - arrange for an expedited consultation or procedure
    - arrange for laboratory or diagnostic investigations
    - inform the referring physician of results of diagnostic investigations;
    - arrange a hospital bed for a patient
vi. If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
vii. Payable in addition to any visit fee on the same day if medically required and does not take place concurrently with the patient conference. (i.e. Visit is separate from conference time).
viii. Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.
ix. The claim must state start and end times of the service.
x. Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility.
xi. Not payable for simple advice to a non-physician allied health professional about a patient in a facility.
xii. Not payable in addition to G14015 GP Facility Patient Conference fee, G14016 Community Patient Conference fee, or G14017 Acute Care Discharge Planning Conference fee as these fees are replaced by G14077 for those Family Physicians who have submitted the GP Attachment Participation code.
xiii. These payments are not available to physicians who are employed by or who are under contract to a facility or health authority who would otherwise have participated in the conference as a requirement of their employment.
xiv. They are also not available to physicians who are working under salary, service contract or sessional arrangements who would otherwise have participated in the conference as a requirement of their employment.

(See FAQ #6.30 for the definition used by GPSC regarding physicians under APP)

Frequently Asked Questions about G14077 GP Attachment Patient Conference Fee

5.1 What is the difference between the G14077 GP Attachment Patient Conference Fee and the original G14015 GP Facility Patient Conference, G14016 GP Community Patient Conference and G14017 GP Acute Care Discharge Planning Conference fees?

GPSC has received significant feedback on the barriers of the original Conference fees (G14015, G14016 & G14017). The G14077 GP Attachment patient Conference fee essentially amalgamates the original conference fees G14015 (Facility Patient Conference Fee), G14016 (Community Patient Conference Fee) & G14017 (Acute Care Discharge Planning Conference fee) and also removes the barriers that existed with these initial

ones. FPs participating in the Attachment Initiative will never again have to remember the original codes and the requirements for billing them.
Now, there is a single code, G14077, with a total of 18 units per calendar year and 2 units per calendar day (same as the combined totals for the original fees) but with much more flexibility in when, where and how they can be accessed:

- Can be used when the patient is located in the community, acute care, sub-acute care, assisted living, long-term or intermediate care facilities, detox units, mental health units, etc. etc.
- Can be provided/requested at any stage of admission to a facility from ER through stay to discharge)
- Need to conference with at least 1 allied health professional (including physicians) regardless of location.
- Can be done in person or by telephone.
- Can be initiated by either the FP or the Allied Health Professional.

5.2 Is G14077 GP Attachment Patient Conference Fee billable for patients in acute care? Is the phrase "not billable for simple advice given to a health care professional about a Patient in a facility" only intended to cover that specific instance and a case of a call for other than simple advice (for example) is billable even if the patient is in a facility?

The Attachment Patient Conference Fee (14077) is much more flexible than the three conference codes it is replacing (14015, 14016, 14017). FPs participating in the GPSC Attachment Initiative will no longer bill the original codes. They will only bill the 14077 for conferences that occur for any patient in their practice (there are no diagnostic requirements with the 14077 unlike with the original conference codes which were restricted to Frail elderly, Palliative/End-of-Life, Multiple Co-morbidities, Mental Health). There is also no patient location restriction for this new conference fee. So patients may be in the community or in a facility (any facility including acute care and even in ER). All of the conferencing codes have the same time requirements – billed per 15 minutes or greater portion thereof, requires start and end time.

Simple/brief advice to a non-physician allied health practitioner is covered using 13005 for patients in community "care" (eg. home health, palliative care, and public health services provided in the home) or any facility except acute care.

5.3 What "Allied Health Professionals" are included in order to bill G14077 GP Attachment Patient Conference Fee?

For the purposes of this initiative, an Allied Health Professional is a trained professional with a scope of practice that allows the provision of medical and medically related services to patients. The conference must involve discussion of care within the scope of practice of the Allied Health Professional. Examples would be RNs or NPs working within the FP practice, supporting the care of the FP's patients. Delegating the telephone call to an MOA is not included for the billing of G14077 GP Attachment Patient Conference Fee but is accepted for the billing of G14079 GP Telephone/e-mail Follow-up Management fee.

5.4 If a hospital has a multidisciplinary team potentially that meets to discuss the needs of inpatients with respect to issues such as placement, nutritional support, physio or rehab, and the condition of the patient determines that there is the necessity of a physician meeting with the group, will this team meeting be eligible for billing G14077 GP Attachment Patient Conference Fee?

Yes, FP conferencing with this group of Allied Health Professionals (either in person or by teleconference) would qualify for the use of the new Attachment Patient Conference fee G14077 regardless of the underlying patient medical condition that requires the conference to occur. There is a limit of 2 units (30 minutes) per calendar day per

patient, and with the 18 units per calendar year, there is increased flexibility for using this fee across locations/scenarios of conferencing.

5.4 Are locums able to access the G14077 GP Attachment Patient Conferencing Fee when covering in an Attachment Participating practice?

Yes. Locum physicians are eligible to have the G14077 billed for conferencing with allied health professionals when covering an Attachment participating host FP, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

5.5 In a multi-doctor Attachment participating clinic, is G14077 GP Attachment Patient Conference Fee billable for conferencing services provided by one of the clinic FPs covering for a patient's FP when their own FP is not available (eg. Holiday or out of hours coverage)?

If all GPs in the clinic group participate in attachment and the patient in question is attached to one of them, then conferencing is appropriate. If the covering doc is conferencing for a patient that does not belong to the group (ie. either another non-group FP or patient is unattached), then none of the conferencing fees would be appropriate, as these are restricted to the FP who provides the community MRP care for the patient on an ongoing longitudinal basis. When covering for a colleague in the absence of a locum, these patients may be booked or may be a walk-in/fit-in on any given day. Some of these conferences could occur on the weekend or in the evenings by the doc "on-call" for the group.

The important point is about the underlying relationship with the FP and the fact that in multi-doctor clinics, while the majority of the care is provided by the FP the patient is attached to, there are situations where the other docs must cover not only out of office hours but also during office time. How each group of docs arranges this coverage is variable. It is not about where in the clinic the patient is care for. It's about the status of patient (attached or not) and well as whether or not the treating physician is participating in attachment and has submitted code G14070 or G14071 in the case of a locum at the clinic.

Division Funding and How to Access It

A total of $40 million is available to develop and implement plans that will increase access to primary care in BC communities. This includes $24 million discretionary MoH support for non-physician expenditures negotiated in 2012 as part of the Physician Master Agreement, and an additional $16 million in one-time funding being provided by the GPSC. Funds are available both for physician involvement in the Attachment initiative's planning or execution, as well as for infrastructure.

It is anticipated that this work will take place largely through Divisions of Family Practice, which now number 32 and represent an estimated 92-95% of FPs. In smaller communities that do not have or need a Divisional structure; a process for their inclusion is being developed.

Divisions enable FPs to be part of building a better primary care system in their own communities, and to engage collaboratively with their Health Authority and the GPSC. A coordinated approach is seen as the only way that Attachment will be able to succeed and be sustained.

The Attachment initiative will engage FPs in assessing their local primary care system and provide funding for the development and implementation of a community plan to support FPs in their practices, improve the coordination of patient care and expand access to FPs wishing to accept patients.

Interested Divisions should contact their Physician Engagement Leads for more information on how to apply for this funding. A Division toolkit is being developed and will be available shortly through the provincial Divisions team.

6. General Frequently Asked Questions about the GPSC Attachment Initiative

6.1 What is A GP for Me?

A GP for Me is a program sponsored by the Ministry of Health (MoH) and the BC Medical Association (BCMA) to support doctors providing longitudinal patient care, support existing doctor patient relationships, and provide access to family doctors for those British Columbians who want one. The initiative has also been called the Attachment initiative. The terms are interchangeable.

6.2 What is the GPSC definition of Full Service Family Practice (FSFP)?

The GPSC defines the Full Service Family Practitioner as the FP who has a longitudinal ongoing relationship with his/her patients. It is not about any specific set of services being provided by a specific individual, however, if the FP does not provide a particular service needed at any given time (eg. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care with the patient's family physician.

6.3 What funding is available to family doctors?

GPSC has allocated the following funds to A GP for Me:

- $40 million to Divisions of Family Practice over the next three years to develop and implement local plans to improve primary care capacity and find doctors for people looking for them.
- $60.5 million for two years for a new suite of attachment fees available to family physician fees available as of April 1, 2013, including:
  - Patient-family doctor telephone consultations;
  - Enhanced fees to care for patients with chronic conditions;
  - Fees for taking on new patients with complex care needs.

6.4 How can doctors access the funding to support their Attachment related work?

For A GP for Me, local divisions of family practice will administer the portion for the community-based planning and implementation. Local divisions will not administer the Attachment fee codes; these will be submitted through MSP Teleplan.

The fee codes for the Attachment initiative will be **available to all family doctors who submit the MSP fee G14070** 'GP Attachment Participation Code', at the beginning of each calendar year. This will in turn open the door to the new Attachment initiative suite of fees. Billing the zero sum fee code signifies that:

- You are providing full-service family practice services to your patients, and will continue to do so for the duration of that calendar year;
- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'compact'. See FAQ 6.6 for details.
- You have contacted your local division of family practice to share your contact information and to indicate your desire to participate in the community-level Attachment initiative as you are able. See FAQ 6.20 and FAQ 6.21 for more information.

Prior to submitting the GP Attachment Participation Code, each participating Family Physician must register their intent to participate in A GP for Me with their local division, even if he/she is not a member of that local division. This will assist the local division to understand how many doctors in their area are prepared to support Attachment initiative efforts. Division contacts are available online at www.divisionsbc.ca.

The fee codes for the Attachment initiative will **also be available for locums are working for a Family Physician who is participating in the attachment initiative and who have submitted the MSP fee G14071** 'GP Locum Attachment Participation Code', at the beginning of the calendar year or prior to providing the first locum

coverage for a family physician participating in the attachment initiative. Billing the zero sum fee code signifies that:

- You are providing full-service family practice services to the patients of the host physician, and will continue to do so for the duration of locum coverage for a family physician participating in the attachment incentive.
- You have contacted the Divisions of Family Practice central office (AGPforMe@bcma.bc.ca) to share your contact information and to indicate your desire to participate as a locum in the community-level Attachment initiative as you are able. Refer to A GP for Me - Frequently asked Questions Q20 and Q21 for more information.

Prior to submitting the GP Locum Attachment Participation Code, each participating Family Physician Locum must register their intent to participate in A GP for Me with the Divisions of Family Practice central office.

6.5 Do I need to be a member of my local division to qualify for the attachment fees?

No, the Attachment initiative fee codes will be available to all family doctors providing longitudinal care and that comply with the criteria for the Attachment initiative as outlined in Question 4.

For physicians that have hybrid practices with both longitudinal patients and walk-in patients, the patient specific attachment fee codes can be billed only for those patients for whom the physician has accepted Most Responsible Physician (MRP) responsibility for their community-based care.

6.6 What is meant by my needing to 'confirm your doctor-patient relationship with your existing patients'?

Doctors and patients participated in the drafting of an informal doctor-patient conversation (sometimes referred to as a 'Compact') that is being used to confirm patient attachment as part of the A GP for Me initiative.

The three prototype Attachment communities helped develop wording for this doctor-patient conversation and, more recently, focus groups were held to test the language of the compact. Here is the resulting wording:

As your family doctor, my practice team and I will:

- *Provide you with the best care that we can*
- *Coordinate any specialty care that you need*
- *Offer you timely access to care within the best of our ability*
- *Maintain an ongoing record of your health*
- *Keep you up-to-date on any changes to the services offered at our office*
- *Communicate with you honestly and openly to address your health care needs.*

As my patient, I ask that you:

- *Seek your health care from me and my team whenever possible*
- *Identify me as your doctor if you have to visit an emergency facility or other health care provider, so they can provide me with information about your treatment for your medical record*
- *Communicate with me honestly and openly so that we can best address your health care needs.*

You do not need to call in your patients to discuss this or mail information individually. Materials have been created that provide this information to patients; you may choose to use these materials in your office and offer them to your patients. You can see the materials at bcma.org; click on News and it will direct you to the appropriate section.

You can also contact the provincial Divisions team to order paper copies for distribution in your office. (www.divisionsbc.ca)

6.7 Isn't attachment just another term for capitation?

No. Capitation is a method of payment and the Attachment initiative in BC does not change the payment method for a physician.

Also, this is not a restricted rostering. Participation is entirely voluntary for both patients and physicians. Doctors and patients will each still be able to choose to work with one another, and either may decide to opt out of their doctor-patient relationship at their discretion.

6.8 What are the criteria for billing the new attachment fees?

Any family physician wishing to participate in the Attachment initiative may do so by submitting the MSP "Attachment Participation" code (G14070) at the beginning of each calendar year. Any locums who will be working for a Family Physician who is participating in the attachment initiative can have access to the new attachment fees provided they have submitted the MSP fee G14071 'GP Locum Attachment Participation Code', at the beginning of the calendar year or prior to providing the first locum coverage for a family physician participating in the attachment initiative. Submitting code G14070 or G14071 verifies ongoing participation in the Attachment Initiative and your continued compliance with the participation criteria as outlined in question 4.

6.9 What proof will the Ministry require that doctors are confirming their relationships with existing patients?

Through the MSP "Attachment Participation" code G14070 the Attachment participating Family Physician has committed to confirming the relationship with their patients. There is no requirement to register individual patients to confirm the relationship.

6.10 Are we expected to take on new patients?

No, participation in the Attachment initiative is voluntary. If you choose to participate you will not be forced to take on patients that you do not want; the commitment states you must participate at the community level "as you are able".

However, the program is designed to help create capacity within the existing system:

- The telephone visits available through the Attachment initiative suite of fee codes have been shown in other jurisdictions to increase efficiency and therefore practice capacity.
- The new Attachment incentives related to patients with complex, chronic conditions are designed to support you if you do choose to take on these individuals.
- The three Attachment prototype communities have demonstrated that community-level planning through local divisions has created capacity.

So, you may find that participation in the Attachment initiative does create capacity in your practice, enabling you to take on more patients if you wish.

6.11 Are we expected to work longer hours?

No; is it not the GPSC's intention to ask doctors to work harder or to put in extra hours. We expect that practice capacity will be enhanced through the practice-level and community-level supports included in the Attachment program.

All aspects of this program are optional. We are recognizing and supporting doctors who are already providing longitudinal care, help those who want to strengthen relationships with existing patients and increase practice efficiency, and provide compensation to those who are willing to take on new patients, including those with more complex care needs.

6.12 How will these programs help doctors?

Through A GP for Me, family physicians will be provided with both practice-level and community-level supports. New fees will improve practice efficiencies through telephone 'visits', and family physicians will be better compensated and supported for the time required to provide longitudinal care to more complex patients.

Community-level efficiencies can be developed by local divisions, again increasing the capacity of primary care in the community in which you work.

Family doctors will also have opportunities for input – through Divisions of Family Practice – into primary care planning at the community level, aimed at coordinating and, if needed, enhancing access to services.

Finally, family doctors will be positioned at the centre of primary care delivery, and awareness of their important role will be built through focused communication and enhanced patient relationships.

6.13 How will this initiative help patients?

Patients who already have a family doctor will have new options for accessing care, through things like telephone fees at the practice level and enhanced access to services at the community level. They will also have better continuity of care by a GP when they are in hospital.

Over time, patients who are currently without a family doctor will also benefit. Work by Divisions will both increase local primary care capacity and introduce means of finding doctors for patients who are looking for one.

6.14 How do you know this program will be successful?

Over the last three years, A GP for Me has been prototyped in three communities: Cowichan Valley, Prince George and White Rock-South Surrey. Approximately 300 family physicians participated in that phase through their local division of family practice, and they were successful in finding doctors for about 9,000 people who did not previously have one. In one community, there is currently no wait time if a resident is looking for a family doctor. The approaches that were tried in these three communities will be helpful input to doctors in other parts of BC as they develop their own local plans.

6.15 Were any doctors consulted in the development of these programs?

Doctors have been integral to shaping and growing both the Attachment and In-Patient Care initiatives. Nearly 400 family physicians in BC have contributed thus far. Family physicians have been involved in every step of this process:

- as members of the GPSC shaping the high-level framework of both initiatives,
- as members of both the BC Medical Association and the Society of General Practitioner boards of directors, reviewing and approving the work of the GPSC,
- as members of the provincial attachment working group from the prototype communities that met monthly to discuss learnings and projects at the community planning level, and
- as members of the prototype communities, working to test and implement community-level plans in their practices. Approximately 300 physicians tested and implemented the prototype plans across three communities.
- As well, approximately 150 doctors have been involved through their local division of family practice in shaping the In-Patient Care initiative.

In addition, doctors and patients have been consulted over the last several years through workshops to establish a definition for patient attachment and outline the responsibilities of both physicians and patients in this acknowledged relationship. Finally, many divisions across the province have been addressing various elements of attachment through their CSCs, such as collecting and analyzing data from practices, the

community, facilities and the province to better understand the number of unattached patients and the priority areas for improving the health of vulnerable populations.

6.16 Will we be allowed to end the Patient-Physician Relationship or are we committed to them forever by the attachment program?

Doctors will still be able to end the Patient-Physician Relationship, as long as they adhere to the College of Physicians and Surgeons of BC policies found at: www.cpsbc.ca/files/u6/Ending-the-Patient-Physician-Relationship.pdf

6.17 How many people in BC need a family doctor?

Provincial data shows that about 176,000 people in BC are looking for a family doctor. There are more people than this who do not have a regular doctor, but not everyone is interested in having one.

6.18 I had heard there was going to be an attachment fee for each confirmed patient in a doctor's practice. Has this changed?

This idea was discussed but discarded. Doctors did not feel that the fee would help make it more feasible for them to take on new patients and the administrative burden was too onerous. As well, patients indicated that they felt their doctor was already attached to them; a formal conversation could be odd and sometimes confusing. The revised approach provides new fees and other supports to doctors for the longitudinal care they are already providing, and was developed as a direct result of physician feedback.

6.19 I provide longitudinal care but my practice is already full. So a new doctor can access these new fees and reap economic benefits, as can doctors that haven't previously been providing longitudinal care. Why can't I?

Several of the new fees being introduced as part of the Attachment initiative are aimed at rewarding longitudinal care that is already being provided by family doctors. These include fees for telephone consultations and an expanded scope of complex care fees for your existing patients. We believe that these new fee codes make it possible for physicians to work in more flexible ways that traditional fee codes don't, such as accurately compensating you for the time required for caring for complex patients, or enabling patients to talk to you on the phone for matters that don't require an in-person visit. New guidelines regarding patients who qualify for complex care billing codes enables doctors to include more patients in this billing category as well.

You do not need to take on new patients to benefit. However, if these other measures help you increase efficiency in your practice and you choose to take on new patients at some point in the future, you will also have access to the new patient fees.

6.20 I'm a member of a local division but I don't want to participate in this initiative. How do I know that the division won't move ahead in doing this work even though I don't want to?

Participation by divisions is optional. Division boards are encouraged to solicit feedback from their members and we encourage you to communicate your thoughts to your division leadership. If the majority of a division's membership supports the division taking on attachment strategies such as community planning, the division may move ahead in participating in attachment activities.

If your Division does decide to participate in the Attachment initiative, your own participation is still voluntary. You may choose not to participate in any A GP for Me activities or to bill the attachment fees.

However, if you choose to bill the Attachment initiative fees, you must be willing to participate in the community planning work that your division undertakes. The degree that you participate in the planning is up to you. The division may request your participation in activities such as:

- Where able, attend planning meetings or consultations.

- Participate in testing out new ideas with your colleagues such as new scheduling techniques, practice support, or surveys.
- If interested, provide clinical support to new programs in the community – and be fairly compensated for your efforts.

The three prototype communities' learnings provide good examples of the kinds of activities your community may undertake, and that you would be asked to consider participating in.

6.21 I want to participate, but I don't have a local division that is participating. What can I do?

While over 95% of Family Physicians now have access to a local division, there are still some communities that do not have one. If you do not have a local division, you should consult your local colleagues to see if there is interest in participating. If there is, contact us through www.divisionsbc.ca to indicate your interest and you will receive assistance in establishing either a division or an alternate process if forming a full division is not feasible.

If you do have a local division, but the division has decided not to proceed at this time with 'A GP for Me', you are entitled to submit the Attachment participation code as long as you meet all requirements, and then also to access the Attachment fees. We would also encourage you to make your voice known to your local division, and encourage your local colleagues to participate as well.

6.22 Are health authorities involved in this attachment work?

Health authorities can offer resources and support that can make a real difference in care offered to patients in your community. Note that the attachment work is an initiative of the GPSC for physicians to improve primary care. This initiative will be physician-led work in communities where doctors and divisions decide to take on this work. It is up to local divisions to involve health authorities in the attachment community-level work at their Collaborative Service Committees when and if it is appropriate.

There are great opportunities for divisions to harness the positive work that health authorities are pursuing in the areas of primary health care improvement. Divisions can work with their local health authority and other important partners through their CSC to make a difference for local patients. The three prototype communities' learnings provide good examples of the effectiveness of these partnerships.

6.23 Does the College of Physicians and Surgeons support the telephone fee code?

The College of Physicians and Surgeons has not voiced any problems with telephone fee codes. For details on what is expected for documentation when giving advice over the phone, contact the Canadian Medical Protective Association.

6.24 How does the unattached complex high needs patient attachment fee work?

The unattached complex high needs patient attachment fee is billable once per patient. If the fee is billed in the same year by a second family physician it will be rejected, unless there is a note that says the patient has moved communities and is again unattached. The fee is not billable when patients transfer from one family physician to another within the same community. Also, these patients must be referred to a family physician; for more details refer to the fee description.

6.25 Are there any fee codes that relate to physicians attending to patients in a residential facility?

There are several codes that can be used when attending to patients in a residential facility. The unattached complex/high needs patient attachment fee can be used for frail unattached patients admitted for long-term care. The attachment patient conference fee code is billable on patients in the community or any facility, including long-term care.

6.26 If a participating family physician accepts only some patients and not all patients required, will there be repercussions from the College of Physicians and Surgeons?

The College of Physicians and Surgeons recognizes the clinical life of a family physician is complex; there are many reasons, both professional and personal, for being able to take on a patient at some points and not others.

6.27 Do I have to register with a Division of Family Practice to access the new fee codes through the A GP for Me initiative?

Yes. For more details please see FAQ 6.4 and FAQ 6.5 above.

6.28 What if only half of my patients are eligible for the new fee codes? Do I only register those who are eligible or all of my patients?

Registration for participation in 'A GP for Me' is done by physician, not by patient. For family physicians, a single, zero-sum participation code must be submitted each calendar year to access the fee codes for that year. Patients do not need to be registered. See FAQ 6.5 above.

For physicians that have hybrid practices with both longitudinal patients and walk-in patients, A GP for Me fee codes can be billed only for those patients for whom the physician has accepted Most Responsible Physician (MRP) responsibility for their community-based care.

6.29 How does A GP for Me and the associated fee codes work with EMRs?

The fee codes themselves are independent of being on an EMR or not. The fee codes will need to be entered into your EMR if you are using one. Software products vary; some allow you to enter new fee codes, some do not. If in doubt, contact your software vendor. The MSP Teleplan system began accepting the new fees as of April 1, 2013.

6.30 How does GPSC define Alternately Paid Physicians "APP" for any of its incentives?

For the purposes of GPSC incentives, including both the Attachment and In-patient Initiative incentives, the GPSC is referring to physicians who are working under MoH or Health Authority paid APP contracts. Local group decisions to pool FFS billings and pay out in a mutually agreeable way (eg. per day, per shift, per hour, etc) are not considered APP by GPSC. If the services that are supported through the GPSC incentives are already included within the time for which a physician is paid under the contract, then it is not appropriate to also bill for the GPSC incentives.

6.31How does the provision of Care by a Nurse Practitioner relate to the GPSC incentives, including those of the Attachment Initiative?

The intent of the Attachment Initiative and its incentives is to facilitate the attachment of currently unattached complex/high-needs patients to a Family Physician, as well as support the relationship between patients and their personal Family Physician. The majority of the GPSC incentives are payable for services provided to patients by the FP who is the community Most Responsible Family Physician (MRFP) for those patients, or by the FP covering for the community MRFP (locum or call group). GPSC initiatives are not payable for services to patients by an NP when the NP is the Most Responsible Provider, nor are they payable to FPs for consulting with NPs on patients for whom the NP is the Most Responsible Provider. While collaborative/shared care with AHPs, including NPs does support the FP-Patient relationship, it is not directly billable under any of the GPSC incentives.

GPs with Specialty Training (eg. Emergency Medicine, Palliative Medicine, etc) may submit fee item 14022 when providing advice by telephone to allied healthcare providers (AHP), including FPs, Specialists, NPs and other AHPs, provided all requirements are met.

Appendix 1.

Society of General Practitioners of BC

Locum/Host Check List:

- ☐ Length of locum & daily hours?
- ☐ On-call obligations and arrangements?
- ☐ Hospital work & obtaining privileges?
- ☐ Obstetrics?
- ☐ Office staffing?
- ☐ Specialty backup?
- ☐ Review daily office bookings & billings procedure
- ☐ Place to stay?
- ☐ Income percentage split? Office vs. Out-of-office (e.g. Obstetrics, hospital care)
- ☐ What if the host doc is not FFS? Can you receive host doc's APP bonuses?
- ☐ Guaranteed minimum income?
- ☐ Billing for uninsured services?
- ☐ Which GPSC incentives can be billed for services provided by locum? Some GPSC incentives cover more than a single service (e.g. CDMs and Complex Care – covers 1 year period) and if included in locum services, need to mutually agree on any adjustment to calculations for income percentage split to reflect this.
    - Attachment Practice
        - Yes
        - No
    - Complex/high-needs Unattached Patient Attachment (Intake assessment and planning visit)
    - Complex Care Planning
    - Mental Health Planning
    - Palliative Planning
    - Prevention
    - Conferencing
    - Patient Telephone Calls
    - Chronic Disease Management annual bonuses

(See SGP website www.sgp.bc.ca for Locum Contract Template)